SHELTER + CARE PROGRAM
VERIFICATION OF DISABILITY FORM

DATE: _____

TO: _____ **FROM:** _____

_____ _____

_____ _____

_____ _____

_____ has applied for housing assistance under the Shelter + Care program of the U.S. Department of Housing and Urban Development (HUD). HUD requires the verification of all information that is used in determining this person's eligibility or level of benefits.

We ask your cooperation in completing the attached form and returning as quickly as possible to the provider listed above. Your prompt return of this information will help assure timely processing for housing assistance. Enclosed is the release completed by the applicant consenting to the release of information about their disability.

Please do not hesitate to call with any questions or concerns.

Sincerely,

SHELTER + CARE PROGRAM
VERIFICATION OF DISABILITY FORM

INSTRUCTIONS:
A qualified professional with one of the following credentials (MD, DO, LCPC, LCSW, APRN-BC, NP) must complete this form.
Sections 1, 2 and 3 of the form apply to:

_____DOB:_____

SECTION 1: APPLIES TO INDIVIDUALS WITH PSYCHIATRIC DISABILITIES, CHRONIC SUBSTANCE ABUSE AND HIV/AIDS

The above named individual is an adult having a physical, mental, or emotional impairment that:
(a) is expected to be of long-continued and indefinite duration

AND

(b) substantially impedes the person's ability to live independently

AND

(c) is such that the person's ability to live independently could be improved by more suitable housing conditions.

If a, b, and c above are true then please check 'Yes', otherwise check 'No' ☐ YES ☐ NO

SECTION 2: APPLIES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

The above named individual is an adult with a chronic and severe developmental disability which:

(a) is attributable to a mental and/or physical impairment or combination mental and physical impairments; **AND**
(b) was manifested before the person attained age 22; **AND**
(c) is likely to continue indefinitely; **AND**
(d) results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency; **AND**
(e) reflects the person's need for a combination and sequence of special interdisciplinary or generic care, treatment, or other services which are of lifelong, or extended duration and are individually planned and coordinated.
(f)

If a, b, c, d, e and f above are true then please check 'Yes', otherwise check 'No' ☐ YES ☐ NO

SECTION 3: Applies to all applicants

The individual named above is an individual with (a): (Check all that apply)

☐ Psychiatric Disability
☐ HIV/AIDS
☐ Other Disability _____
☐ Chronic Alcohol Abuse
☐ Chronic Substance Abuse

_____ _____
Name and credentials of Provider **Agency and Telephone Number**

_____ _____
Signature **Date**